STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G704	A. BUILDING 00 B. WING	04/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	6630 RHINESTONE DR ELLETTSVILLE, IN 47429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000		W000000		
	This visit was for the Post Certification Revisit (PCR) to the investigation of complaint #IN00144572 completed on 3/13/14. This visit was in conjunction with the PCR to the PCR to the investigation of complaint #IN00142656 completed on 3/13/14. Complaint #IN00144572 - Not corrected. Survey Dates: April 17, 22, 23 and 24, 2014 Facility Number: 003773 Provider Number: 15G704 AIM Number: 200447340 Surveyor: Steven Schwing, QIDP These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/30/14 by Ruth Shackelford, QIDP.			
W000149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 5 of 15 incident/investigative reports reviewed affecting 4 of 5 clients living in the group home (A, C, D and E), the facility neglected to implement its policies and procedures to prevent abuse of the clients, ensure staff immediately reported abuse to the administrator, ensure incident reports were submitted to the Bureau of Developmental	W000149	All investigations have been completed. The agency has identified a need to transfer client E to another site in order to further protect him from being the target of aggression. This will be accomplished following the end of the school year and his eighteenth birthday. Several other customers will be transferring to other settings in	05/24/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Disabilities Services (BDDS) in a timely manner and implement corrective actions as recommended in an investigation. Findings include: A review of the facility's incident/investigative reports was conducted on 4/17/14 at 12:40 PM and indicated the following: 1) On 3/21/14 at 9:30 PM, client A was running up and down the hallway. Client E came out of his room and client A pushed client E into the wall. The Bureau of Developmental Disabilities Services report, dated 3/22/14, indicated, "[Client E] got up and kept on walking. There are no signs of injury and no marks." The facility neglected to conduct an investigation of client to client abuse. On 4/23/14 at 10:34 AM, the Director of Residential Services (DRS) indicated the facility did not conduct an investigation. The DRS stated, "apparently it wasn't done." The DRS indicated the previous Network Director was supposed to conduct the investigation. The DRS indicated client to client aggression was considered abuse and should be investigated. The DRS indicated abuse of the clients should be prevented by the facility and the facility had a policy and procedure prohibiting abuse of the clients. 2) On 3/24/14 at 9:45 PM, the BDDS report, dated 4/4/14, indicated, in part, "[Client D] was reportedly aggressive towards staff, and not redirectable. After almost an hour of continuous aggression, staff decided to escort [client D] to his room, where he could hopefully calm down. Once [client D] was inside his room, DSP [staff #11] allegedly		the near future. The Network Director/QIDDP will review and revise all customers' behavior plans as needed in order to address aggression more proactively. He will then train staff members on the revised plans. Staff members will also be retrained on the reporting process and a Competency Based Task Analysis form, or probe, for reporting abuse and neglect will be utilized to test their knowledge. The Director of Residential Services will test all Network Directors/QIDDPs and the Rhinestone Team Manager using the probe and the Team Manager will administer this probe to each individual staff member at Rhinestone one time each week for one month and then one time a month for two months. In order to ensure the deficient practice does not recur,the Team Manager will create a Shift Task List to be used each day that will include the assignment of a Shift Lead, who will be responsible for querying all team members about potentially reportable occurrences at the end of the shift and reporting them according to agency policy, if they haven't already been reported during the shift. Ongoing monitoring of these corrective actions will be accomplished through continued observations. The Team Manager, Network Director/QIDDP and Director of	

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	slammed his (client D's) bedroom door shut, and then held it closed. Reportedly the other staff on shift, [staff #3] and [staff #6], told [staff #11] he could not do that, but he continued to hold the door for approximately 15 minutes. Another report was filed related to this employee related to an incident on 3/29/14 and a BDDS report was filed at that time. This writer obtained the internal incident report for that incident on 4/4/14, which also included information about this separate event." On 4/23/14 at 10:34 AM, the DRS indicated the timeframe for staff reporting suspected abuse was immediately. The DRS indicated the timeframe for reporting incidents to BDDS was 24 hours. The DRS indicated the facility substantiated the incident as seclusion. 3) On 3/29/14 at 3:00 PM, the BDDS report, dated 4/2/14, indicated, in part, "It was reported by [staff #3] that [staff #11] smacked [client D's] hand away when [client D] tried grabbing at him. This incident is under investigation and [staff #11] has been put on Administrative Leave." The investigation, dated 4/9/14, indicated, in part, "These incidents (3/24/14 and 3/29/14) are being investigated as allegations of seclusion and physical abuse...." The Findings section indicated, "Substantiated, the findings support the alleged event as described." The Summary indicated, "[Staff #11] admitted to holding [client D's] door closed during an aggressive episode. This is seclusion, which is prohibited by LifeDesigns. The reporting staff and [staff #11] gave inconsistent accounts of the incident, so this writer could not confirm exactly how long he		Residential Services will observe the milieu three times a week for two months, then the Team Manager and Network Director/QIDDP will observe two times a week for one month. Observations will be documented on the standard agency observation form.	

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	held the door closed. [Staff #11] may have grabbed [client D's] arm in the process of attempting to get [client D] to stop grabbing his shirt; however, the staff who reported this incident indicated that it did not appear [staff #11] was attempting to harm [client D]; but it as (sic) more of an impulse reaction when [client D] was grabbing him." The Recommendations section indicated, in part, "5. [Staff #3, staff #12 and staff #6] should receive disciplinary action for failure to immediately report the observed events to an administrator, per agency policy." The facility did not provide documentation indicating staff #3, #6 and #12 received disciplinary action. On 4/23/14 at 10:34 AM, the DRS indicated the timeframe for staff reporting suspected abuse was immediately. The DRS indicated the timeframe for reporting incidents to BDDS was 24 hours. The DRS indicated the Home Manager (HM) interviewed the three staff (#3, #12 and #6) and determined staff #3 needed to receive disciplinary action. The DRS indicated the HM was unable to locate the document indicating staff #3 received disciplinary action. The DRS indicated the HM should have sent the disciplinary action form into the office. The DRS indicated all three staff, at this point, should have been disciplined as recommended in the investigation. 4) On 4/11/14 at 7:00 PM, the BDDS report, dated 4/15/14, indicated, in part, "Around 7 PM on Friday, April 11, [client C] reportedly became upset and aggressive after his post dinner bath. He asked [staff #6] to listen to music on the laptop computer directly before he began banging and punching it. When [staff #6] attempted to redirect [client C], [client C] began to scream and spit on [staff			

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	#6] and a nearby peer [client D]. [Client C] hit [staff #6] then punched [client D] in the arm before spitting on [client D] multiple times." On 4/23/14 at 10:34 AM, the DRS indicated client to client aggression was considered abuse. The DRS indicated abuse of the clients should be prevented by the facility and the facility had a policy and procedure prohibiting abuse of the clients. The DRS indicated the facility should submit reports to BDDS within 24 hours. The DRS indicated the staff should immediately report client to client abuse to the administrator. 5) On 4/19/14 at 6:30 PM, client A was in the refrigerator sticking his hands into a bag of cheese. He was redirected out of the refrigerator by staff #2. Client A ran into the living room throwing his helmet and hitting at staff. The three staff attempted to get everyone out of client A's way when client A ran down the hallway and pushed client E into the wall/fire extinguisher. Client E was not injured. On 4/23/14 at 10:34 AM, the DRS indicated client to client aggression was considered abuse. The DRS indicated abuse of the clients should be prevented by the facility and the facility had a policy and procedure prohibiting abuse of the clients. On 4/17/14 at 12:34 PM, a review was conducted of the facility's January 2014 policy on Behavior Support. The policy indicated, in part, "LifeDesigns prohibits the use of unnecessary medications, corporal punishment, physical abuse, the application of electric shock or use of any painful or noxious stimuli, the withdrawal of food and other essentials of human life, seclusion in a			

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	locked room, swearing or other verbal threats, discipline dealt by another LifeDesigns customer, mechanical restraints, denial of religious activity, contingent exercise, negative practice, overcorrection, visual or facial screening, denial of health related necessities, degrades and individual's dignity or use of anything that inflicts pain or humiliation." The Reporting Abuse/Neglect/Exploitation policy, dated September 2013, indicated, in part, "Any employee or consultant having knowledge of an incident of abuse and/or neglect and any suspected incident of abuse and/or neglect must report to the Network Director or the emergency pager upon discovery." The September 2013 policy on Reporting Abuse/Neglect/Exploitation indicated, in part, "BDDS reports must be filed within 24 hours if the incident of suspected abuse, neglect or exploitation involves an adult or child who is residing in a community residential setting." This deficiency was cited on 3/13/14. The facility failed to implement a systemic plan of correction to prevent recurrence.			
W000153	9-3-2(a) 483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 3 of 15 incident/investigative reports reviewed affecting 2 of 5 clients living in the group home (C and D), the facility failed to ensure	W000153	All investigations have been completed. Disciplinary actions for staff members #3,#12 and #6 have been completed. All staff members will be retrained on the reporting processand a	05/24/2014

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	staff immediately reported suspected abuse to the administrator and incident reports were submitted to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law. Findings include: A review of the facility's incident/investigative reports was conducted on 4/17/14 at 12:40 PM and indicated the following: 1) On 3/24/14 at 9:45 PM, the BDDS report, dated 4/4/14, indicated, in part, "[Client D] was reportedly aggressive towards staff, and not redirectable. After almost an hour of continuous aggression, staff decided to escort [client D] to his room, where he could hopefully calm down. Once [client D] was inside his room, DSP [staff #11] allegedly slammed his (client D's) bedroom door shut, and then held it closed. Reportedly the other staff on shift, [staff #3] and [staff #6], told [staff #11] he could not do that, but he continued to hold the door for approximately 15 minutes. Another report was filed related to this employee related to an incident on 3/29/14 and a BDDS report was filed at that time. This writer obtained the internal incident report for that incident on 4/4/14, which also included information about this separate event." On 4/23/14 at 10:34 AM, the DRS indicated the timeframe for staff reporting suspected abuse was immediately. The DRS indicated the timeframe for reporting incidents to BDDS was 24 hours. 2) On 3/29/14 at 3:00 PM, the BDDS report, dated 4/2/14, indicated, in part, "It was reported by [staff #3] that [staff #11] smacked		Competency Based Task Analysis form, or probe, for reporting abuse andneglect will be utilized to test their knowledge. The Director of Residential Services willtest all Network Directors/QIDDPs and the Rhinestone Team Manager using theprobe and the Team Manager will administer this probe to each individual staffmember at Rhinestone one time each week for one month and then one time a monthfor two months. In order to ensure the deficient practice does not recur,the Team Manager will create a Shift Task List to be used each day that willinclude the assignment of a Shift Lead, who will be responsible for queryingall team members about potentially reportable occurrences at the end of theshift and reporting them according to agency policy, if they haven't alreadybeen reported during the shift. Ongoing monitoring of these corrective actions will beaccomplished through continued observations. The Team Manager, Network Director/QIDDP and Director of ResidentialServices will observe the milieu five times a week for two months, then theTeam Manager and Network Director/QIDDP will observe two times a week for onemonth. Observations will be documentedon the standard	

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	[client D's] hand away when [client D] tried grabbing at him. This incident is under investigation and [staff #11] has been put on Administrative Leave." The investigation, dated 4/9/14, indicated, in part, in the Recommendations section, "5. [Staff #3, staff #12 and staff #6] should receive disciplinary action for failure to immediately report the observed events to an administrator, per agency policy." On 4/23/14 at 10:34 AM, the DRS indicated the timeframe for staff reporting suspected abuse was immediately. The DRS indicated the timeframe for reporting incidents to BDDS was 24 hours. 3) On 4/11/14 at 7:00 PM, the BDDS report, dated 4/15/14, indicated, in part, "Around 7 PM on Friday, April 11, [client C] reportedly became upset and aggressive after his post dinner bath. He asked [staff #6] to listen to music on the laptop computer directly before he began banging and punching it. When [staff #6] attempted to redirect [client C], [client C] began to scream and spit on [staff #6] and a nearby peer [client D]. [Client C] hit [staff #6] then punched [client D] in the arm before spitting on [client D] multiple times." On 4/23/14 at 10:34 AM, the Director of Residential Services (DRS) indicated the facility should submit reports to BDDS within 24 hours. The DRS indicated the staff should immediately report client to client abuse to the administrator. This deficiency was cited on 3/13/14. The facility failed to implement a systemic plan of correction to prevent recurrence.		agency observation form. The Director of Residential Services will systematicallymonitor that all recommendations from observations and investigations areimplemented. She will design and utilizea weekly checklist to do so.	

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W000157	9-3-2(a) 483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 2 of 13 incident/investigative reports reviewed affecting 1 of 3 clients in the sample (D), the facility failed to implement corrective actions as recommended in an investigation. Findings include: A review of the facility's incident/investigative reports was conducted on 4/17/14 at 12:40 PM and indicated the following: 1) On 3/24/14 at 9:45 PM, the BDDS report, dated 4/4/14, indicated, in part, "[Client D] was reportedly aggressive towards staff, and not redirectable. After almost an hour of continuous aggression, staff decided to escort [client D] to his room, where he could hopefully calm down. Once [client D] was inside his room, DSP [staff #11] allegedly slammed his (client D's) bedroom door shut, and then held it closed. Reportedly the other staff on shift, [staff #3] and [staff #6], told [staff #11] he could not do that, but he continued to hold the door for approximately 15 minutes. Another report was filed related to this employee related to an incident on 3/29/14 and a BDDS report was filed at that time. This writer obtained the internal incident report for that incident on 4/4/14, which also included information about this separate event." 2) On 3/29/14 at 3:00 PM, the BDDS report, dated 4/2/14, indicated, in part, "It was	W000157	Disciplinary actions for staff members #3, #12 and #6 have been completed and forwarded to the HR Department. The Team Manager and Director of Residential Services were counseled to follow the recommendations of investigations as outlined. In order to ensure the deficient practice does not recur, the Director of Support Services will retrain residential management staff members in investigative policies and protocols and a request for ISDH training on investigations will be scheduled to occur as soon as several open management positions have been filled. The Director of Residential Services will systematically monitor that all recommendations from observations and investigations are implemented. She will design and utilize a weekly checklist to do so.	05/24/2014

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	reported by [staff #3] that [staff #11] smacked [client D's] hand away when [client D] tried grabbing at him. This incident is under investigation and [staff #11] has been put on Administrative Leave." The investigation, dated 4/9/14, indicated, in part, "These incidents (3/24/14 and 3/29/14) are being investigated as allegations of seclusion and physical abuse...." The Findings section indicated, "Substantiated, the findings support the alleged event as described." The Summary indicated, "[Staff #11] admitted to holding [client D's] door closed during an aggressive episode. This is seclusion, which is prohibited by LifeDesigns. The reporting staff and [staff #11] gave inconsistent accounts of the incident, so this writer could not confirm exactly how long he held the door closed. [Staff #11] may have grabbed [client D's] arm in the process of attempting to get [client D] to stop grabbing his shirt; however, the staff who reported this incident indicated that it did not appear [staff #11] was attempting to harm [client D]; but it as (sic) more of an impulse reaction when [client D] was grabbing him." The Recommendations section indicated, in part, "5. [Staff #3, staff #12 and staff #6] should receive disciplinary action for failure to immediately report the observed events to an administrator, per agency policy." The facility did not provide documentation indicating staff #3, #6 and #12 received disciplinary action. On 4/23/14 at 10:34 AM, the Director of Residential Services (DRS) indicated the Home Manager (HM) interviewed the three staff (#3, #12 and #6) and determined staff #3 needed to receive disciplinary action. The DRS indicated the HM was unable to locate the document indicating staff #3 received			

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	disciplinary action. The DRS indicated the HM should have sent the disciplinary action form into the office. The DRS indicated all three staff, at this point, should have been disciplined as recommended in the investigation. 9-3-2(a)			